Southover Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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Overall summary

Southover Medical Practice is a GP practice providing NHS primary care services for approximately 6,000 patients. The practice is in the coastal town of Torquay in Devon.

The practice has a total of five GPs who are supported by a nursing team and an administrative team. Opening hours are between 8.30am to 1pm and 2pm to 6pm from Tuesday to Friday. The practice provides extended opening hours on Monday from 8.30am until 8pm. Outside normal surgery hours patients are directed to an Out of Hours service delivered by another provider.

Southover Medical Practice has one location registered with Care Quality Commission (CQC). This is at Bronshill Road, Torquay, Devon TQ1 3HD. We carried out an announced inspection at the practice on Wednesday 9 July 2014.

We talked with ten patients on the day of the inspection and they were all satisfied with the standard of care, service and treatment they received at the practice. We saw eight comment cards had been completed by patients who used the practice. We noted that all the comment cards were very positive with a recurring theme about the caring attitudes of the staff at the practice. We also spoke with the local area team of NHS England, the local clinical commissioning group (CCG) and with the local Healthwatch as part of this inspection.

We found that the practice was safe, effective, responsive, caring and well led. Patients told us that they were treated with respect and listened to. They said that could access GP appointments and were provided with sufficient information about their care and treatment. Where appropriate, people were supported to manage their own long term conditions. Patients were referred to other services in a timely way. We were provided with a number of examples of where patient's specific needs had been responded to effectively.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service provided was safe and the practice monitored risks and responded to them. Steps had been taken to ensure that equipment, medicines and the environment in which care was delivered were safe. Recruitment processes were in place which protected patients from the risk of recruitment of unsuitable or unskilled staff. The practice was equipped to deal with emergencies and staff understood emergency procedures.

When incidents occurred which affected patient safety and required investigation this was done promptly, however, the lessons from those incidents were not circulated effectively to all staff. As a result of this there was a possibility that necessary changes may not be implemented by all staff.

Are services effective?

The practice was effective. There were sufficient suitably qualified staff with a broad skills mix to provide a good standard of care. Staff maintained their knowledge and used national guidance to promote best practice in the care they delivered.

The practice communicated effectively with other services and maintained strong relationships that supported co-ordinated high quality care for patients. Patients were provided with information, advice and support to maintain their health or make positive changes to it.

Are services caring?

The practice was caring. Patients told us that staff treated them with respect and understanding, they felt that they were listened to and never rushed by staff. Measures were in place to protect a patient's dignity during examinations and to provide reassurance. Patient confidentiality was respected.

Patients told us that they were provided with sufficient information to make informed choices about their treatment and their choices were respected. Patients told us that they received suitable support to manage their own conditions.

Are services responsive to people's needs?

The practice was responsive to patient needs. Patients we spoke with told us that the practice responded well to their individual health needs. The practice had a patient participation group (PPG) which had begun to increase the voice and influence of patients in improving services.

Summary of findings

Patients told us that they were able to get access to an appointment when they wanted one. The most recent patient survey carried out by the practice confirmed this view. Patients said that preferences, such as to see a doctor of the same sex, were responded to where possible.

Where referrals were required to secondary care at hospitals or other health providers these were made promptly and patients were kept informed.

The practice had a complaints policy which was clearly displayed. Patients told us they did not feel the need to complain but knew how to do so. Action was taken in respect of concerns raised.

Are services well-led?

The practice was well led. There was an open and supportive management style. The practice had clear lines of responsibility and accountability and staff understood their roles. Policies and procedures were in place to guide safe, effective, caring and responsive delivery of the service.

Staff felt well supported in their roles and had opportunities to raise issues and to develop. Regular meetings were held to discuss and review clinical practice and business issues. Administrative staff felt supported but said they would value opportunities for more whole practice meetings.

Patient feedback was sought and acted upon and there was a developing patient participation group whose views helped to influence the way the practice was run.

Risks to the safety of patients and the continuity of the service had been assessed and measures were in place in respect of identified risks.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. Their feedback about the service was positive. Patients told us the practice was caring and responsive. They felt safe and confident in the care of the staff and felt respected. Patients talked of being well informed and involved in the decision making process of their care. We were told that the staff listened and followed up on what they said.

Patients said staff were helpful, kind and professional. Individual staff were named and praised as part of the feedback we received and there was also a common theme about all staff being caring.

Patients told us that the appointment system worked well. They understood that if they wished to see a specific doctor they may have to wait longer for an appointment. Patients told us that for urgent matters they could usually get an appointment on the same day. All the patients we spoke with said they felt they staff never rushed them. They told us they were given enough time to explain things to the GPs and ask to questions during their appointments.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure that learning from all incidents is documented and circulated to all staff . This would reduce the risk that necessary changes might not be implemented by all staff.

Southover Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP, a Practice Manager, and a second CQC inspector.

Background to Southover Medical Practice

Southover Medical Practice is a GP practice providing primary care services for approximately 6,000 people in the coastal town of Torquay in Devon.

The town is within the Torbay unitary authority. As a unitary authority Torbay provides all council services within its area. The local economy is affected by seasonal employment and the area has higher numbers of older people than the England average.

Southover Medical Practice has higher than the England average number of patients who are over 75 and just under the England average of patients who are under 18. The practice was aware that a number of their patients lived in areas of social risk and poverty.

The practice has one location registered with Care Quality Commission (CQC). This is at Bronshill Road, Torquay, Devon TQ1 3HD. This is the first inspection of the regulated activities carried out at this practice.

The practice provides a range of services including health screening, immunisations, and management of long term conditions. It has a total of five GPs of whom three are partners in the practice and two are salaried part-time GPs. The GPs are supported by a nursing team consisting of two nurses and a healthcare assistant. The practice has a practice manager and an administrative team of eight. Local community health teams support the GPs in provision of maternity and health visitor services.

Outside of opening times the practice directs patients to an Out of Hours service which is delivered by another provider.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before our inspection site visit we reviewed a range of information that we had about the service. We carried out an analysis of data from our intelligence monitoring system. As part of the inspection process we asked other organisations including the local Healthwatch, NHS England and the clinical commissioning group (CCG) to share what they knew about the service.

During the inspection we spoke with two representatives from the patient participation group which acts as a voice for patients at the practice. We reviewed eight patient comment cards that had been completed by patients who used the practice prior to our inspection.

We carried out an announced visit on 9 July 2014 between 9am and 5.30pm. We observed how reception staff interacted with patients at the practice and how they handled telephone calls.

We talked with ten patients and family members. We spoke with two of the GPs, the practice manager, a nurse, a health care assistant and reception and administration staff. We reviewed the practice policies and procedures and looked at some anonymised patient records.

At the conclusion of the inspection we asked for some additional information to be collated and sent to us by the provider. We reviewed this information and held a telephone conference with the practice to discuss the information on 15 July 2014.

Are services safe?

Our findings

Summary

We found that the service provided was safe and the practice monitored risks and responded to them. Steps had been taken to ensure that equipment, medicines and the environment in which care was delivered were safe. Recruitment processes were in place which protected patients from the risk of recruitment of unsuitable or unskilled staff. The practice was equipped to deal with emergencies and staff understood emergency procedures.

When incidents occurred which affected patient safety and required investigation this was done promptly, however, the lessons from those incidents were not circulated effectively to all staff. As a result of this there was a possibility that necessary changes may not be implemented by all staff.

Safe patient care

Patients we spoke with said they felt safe with staff at Southover Medical Practice. They said they trusted the abilities of GPs and nurses at the practice. We were provided with ten very positive examples of where patients stated they felt safe. These came from comment cards and from conversations we held with patients. One person told us that when they had not felt confident with a GP they were able to see a different GP of their choice.

Patients told us they received prompt treatment and diagnosis. Patients also talked of the on-going treatment, screening and health promotion that took place at the practice. Staff we spoke with were aware of their responsibilities to identify and report incidents and were able to correctly explain how they would report any incidents or concerns that they may have.

Learning from incidents

We were shown four records of incidents at the practice in 2014. These included issues with a referral to other services and prescribing issues. We saw those incidents had been investigated and prompt remedial action had been taken. Individual clinical staff were responsible for serious event reporting for any incident they identified. Records showed that where there was a requirement to notify other organisations, such as the local area team for NHS England (LAT), this had been done.

We were told that learning from those incidents was discussed at monthly clinical governance meetings. However, we found that the minutes of clinical governance meetings did not always include the detail of those discussions. We found that although records showed that the incidents were dealt with promptly, the learning points from incidents were not always clearly identified or circulated around the practice. As a result of this necessary changes to improve patient safety might not be identified and implemented by all staff.

Safeguarding

The practice had procedures in place to identify and respond to risks of harm or abuse relating to children and vulnerable adults. The practice had a clear safeguarding process and one of the partner GPs was a nominated safeguarding lead. We were provided with two recent examples of how the practice had identified potential safeguarding risks and had responded promptly and appropriately to protect people at risk.

The GPs had a weekly safeguarding meeting with the local community health visitors who were based at the practice. Health visitors told us that this practice was very responsive to safeguarding issues. Health visitors used a compatible IT system and GPs and health visitors could access the same on line patient records and risk warnings. This allowed the practice and the health visitors to make timely exchanges of information about patients at risk and ensured GPs and nurses had access to the most up to date information.

Nursing staff, GPs and administrative staff at the practice spoke knowledgeably about safeguarding children and vulnerable adults. They demonstrated awareness of how to identify and escalate concerns. We saw that staff had ready access to the contact telephone numbers for the local safeguarding teams if they needed to raise concerns.

The practice had a whistleblowing policy. This informed staff how they could raise concerns with external agencies, such as social services or the police, if they felt that concerns were not being acted upon at the practice. The staff we spoke with were familiar with the policy.

Monitoring safety and responding to risk

The practice completed risk assessments to ensure the health and safety of patients, visitors and staff. Records showed that the practice had taken preventative action in respect of safety risks. This included ensuring that staff had received fire safety training and that the practice had annual fire risk assessments completed by an independent company. Annual safety checks on the premises and

Are services safe?

equipment had been carried out and we were shown that those checks had been documented. This provided a clear audit trail of the steps the practice had taken to minimise risks.

We were told that any safety alerts or guidance relating to equipment were communicated during the staff meetings or by email. We saw an example of how safety information was circulated. This was a safety alert about new medicines guidelines and had been discussed at a clinical governance meeting. The purpose was to raise awareness and prompt change in clinical practice. Minutes of the clinical governance meeting showed that the guidelines had been discussed and acted upon.

The practice had identified a potential risk with the software used for recording actions following blood tests and had raised this with the IT company responsible. Communications with the company and the practice were on-going at the time of our inspection to adjust the software to ensure tests were processed safely.

The practice had contingency plans in place to ensure continuity of the service in the event of serious and on-going problems with the premises, such as flood or fire. Plans were in place to operate from a nearby practice to reduce the impact for patients.

Medicines management

Patients that we spoke with told us the process for obtaining repeat prescriptions was efficient and well organised. They said they usually received repeat prescriptions within 24 to 48 hours. Patients told us that they discussed reviews and changes to medicines with their GPs.

Staff told us about the systems in place for prescribing medicines and the procedures for authorising repeat prescriptions. We saw there were systems in place which ensured that all prescriptions were authorised by the prescriber.

The practice had recently introduced an additional option of ordering repeat prescriptions on-line. The system had appropriate checks in place to protect confidential information and to ensure that the repeat prescription had been authorised. Two patients told us they had used the new system and had found it to be a very useful option.

Effective systems were in place to highlight when medicine reviews were necessary and to ensure that changes to prescriptions after hospital visits or consultations were identified and acted upon. The staff responsible for the checks demonstrated the system to us.

GPs said that patients were given information about the purpose of their medicines, potential side effects and any necessary monitoring, such as regular blood tests. Patients that we spoke with confirmed this. One person told us they had come in that day to discuss the side effects of their medicine.

There were effective systems in place for obtaining, using, storing and supply of medicines. This included the lead nurse being designated to maintain stocks and audit emergency medicines and vaccines stored at the practice. They showed us the processes they followed. We were shown records of checks to ensure medicines and vaccines were within the expiry date. We visually checked and saw that medicines and vaccines in stock were in date. Daily checks were carried out to ensure that medicines which required cold storage were stored at the correct temperature. We were shown records of those checks which showed that risks in relation to medicines safety and storage were being managed.

Cleanliness and infection control

The practice had a lead GP and lead nurse for infection control. They had worked together on infection control audits and we saw that actions had been taken in respect of those audits. Records showed that as a result of the last audit additional monitoring of acquired infection rates after minor procedures was currently being undertaken. This indicated that there was a cycle of monitoring, improvement and review of infection control practice.

Staff at the practice were supported by up to date information about infection control. Relevant policies had been updated regularly to ensure they were in accordance with current guidance. Nursing staff and GPs showed us their on line access to national guidance documents relating to infection control.

Risks associated with injury and infection from the handling needles and blades were minimised. Staff that we spoke with were familiar with the practice's policy on

Are services safe?

sharps and all treatment areas had a suitable sharps bin. Staff records showed that clinical staff had up to date immunisations, including Hepatitis B, to protect them from risks of contagious diseases.

The practice had appropriate clinical waste storage and a contract with a clinical waste disposal company. Clinical areas were visibly clean and there were sufficient supplies of disposable gloves, aprons and bed rolls. The use of that equipment supported the practice to minimise risks of infection. Surfaces in treatment rooms were wiped down after each patient visit, to prevent cross infection.

We saw records of water supply checks and the arrangements for regular testing for legionella. This indicated the practice monitored safety of the water supply at the practice to reduce the risk of infection.

The practice used contract cleaners and we saw the cleaning schedule for the practice. Records confirmed that the practice manager liaised with the contracted company and visibly checked the standard of cleaning each week. This indicated that the cleanliness of the practice environment was regularly monitored.

Staffing and recruitment

The practice had taken steps to ensure patient safety by reducing the risk of recruiting unsuitable staff. We looked at the recruitment and personnel records for four staff. These showed that there were suitable processes for the recruitment of GPs, nursing and administrative staff. The staff files we looked at had records of pre-employment checks such as appropriate references, and included criminal record checks using the Disclosure and Barring Service (DBS).

The practice had checked that GPs and nursing staff had current registrations with their respective professional bodies. Newly appointed staff received an induction which included an explanation of their roles and responsibilities and access to relevant information about the practice, including relevant policies and procedures. They spent time shadowing more experienced members of staff which enabled them to learn their role effectively and safely.

Dealing with Emergencies

The practice had arrangements in place to deal with foreseeable emergencies. For example, records showed that staff had completed emergency first aid training and that this had been updated regularly. Staff we spoke with knew the location of emergency equipment and its use. The lead nurse was responsible for ensuring that the equipment and emergency medicines were safe and in date. We checked this and found that equipment had been serviced, emergency medicines were in date and there were clear records made.

Equipment

Staff told us they felt they had enough equipment to carry out their role effectively and safely. The practice had arrangements in place to ensure equipment was maintained and safe to use. For example, we saw records that showed portable appliance testing had been completed every two years.

Staff told us equipment used for measuring underwent recalibrations which were required on an annual basis. We were shown records which confirmed that this testing and maintenance of equipment had been completed. The audit trail indicated that necessary steps had been taken to reduce risks to patients from equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Summary

The practice was effective. There were sufficient suitably qualified staff with a broad skills mix to provide a good standard of care. Staff maintained their knowledge and used national guidance to promote best practice in the care they delivered.

The practice communicated effectively with other services and maintained strong relationships that supported co-ordinated high quality care for patients. Patients were provided with information, advice and support to maintain their health or make positive changes to it.

Promoting Best Practice

Staff we spoke with told us they received regular training and access to guidance to support best practice. The GP partners met every day after morning surgery to discuss clinical issues and told us they found it very helpful to share questions about their clinical practice. Clinical governance meetings were held monthly and were attended by GPs, the lead nurse and the practice manager. A guest speaker was invited to each meeting. Recent attendees had included a consultant psychiatrist to discuss mental health issues and a member of the hospital admissions team. GPs told us that the speakers were very helpful in identifying and sharing good practice.

The National Institute for Health and Care Excellence (NICE) regularly publish guidelines which describe best practice in relation to a wide range of treatments and conditions. Minutes of recent clinical governance meetings showed that GPs at the practice had regularly discussed NICE guidance, including recent guidance about treating feverish children. This indicated that the practice used current guidelines to promote good practice.

Management, monitoring and improving outcomes for people

Staff said that the various practice meetings they attended were useful and informative. They said that ideas on how to carry out procedures more effectively and the continual improvement of issues relating to patient care and business needs were addressed.

Patients that we spoke with told us that they felt their condition and treatments were monitored and reviewed to provide the best outcome. They told us that they felt their needs were well met, with several patients expressing a view that this was the best practice they had been to.

The Practice has a system in place for completing clinical audit cycles. We saw evidence of a number of audits and actions to improve patient care, including a prescribing audit with documented completed actions. This helped the practice to ensure more clinically effective use of medicines

Staffing

The ten patients we spoke with and seven comments we read were positive about the professionalism and courtesy of staff at the practice. Individual staff were named by many patients but a theme emerged of patients stating that nursing staff and GPs were good. Two patients expressed that they felt less confident and comfortable with some doctors but expressed overall satisfaction with the service.

There was an effective system in place for monitoring staff performance. The GPs had internal and external networks of clinical support. They had an annual appraisal which was conducted by other GPs who were recognised appraisers. A GP appraiser is responsible for checking GPs have kept up to date with their knowledge, and is someone who works elsewhere.

Nurses' appraisals were undertaken by the practice manager after clinical discussions with the GPs. The nurse we spoke with said they were satisfied with this arrangement and that if any training needs were identified they were confident they would be provided for.

We saw records of appraisal for nursing and administrative staff which monitored performance and identified training needs and development opportunities. For example, one administrative team member had expressed an interest in phlebotomy training (taking of blood samples). They had been supported to learn new skills and were now completing their training.

There was an effective skills mix at the practice. For example, GPs at the practice had a broad range of specialist knowledge or interests. These included respiratory conditions, diabetes, ear nose and throat conditions and family planning.

Are services effective?

(for example, treatment is effective)

Nursing staff and GPs told us they felt the staffing levels allowed them to do their jobs. Locum GPs, who were well known to the practice, were used to cover GP absences. Administrative staff said that they were currently short of staff due to absence of some reception staff. During our inspection we observed that reception staff were busy but patients were not waiting for prolonged periods before being seen or having their telephone call answered.

Working with other services

The service worked very well with other services. We were provided with a number of examples of this during our inspection. For example, health visitors that we spoke with spoke highly of the way this practice worked with them. They described a regular flow of information between the services and said the practice was very responsive. The service also worked well with a community support worker (CSW) who worked with a number of local practices. We spoke with the CSW who said that communication with the practice was very good. We were provided with evidence of how the GPs made prompt referrals to the CSW when patients needed support in relation to caring responsibilities or due to anxiety.

Health, promotion and prevention

We found a great deal of health promotion material at the practice. Information in the form of pamphlets, large print notices and printed sheets were available. However, as information on display was not grouped in themes or conditions it could be difficult for patients to readily identify specific information. Health information was also available on the practice website such as how to recognise or prevent illness and manage long term conditions.

New patients were offered regular health checks depending upon the outcome of their initial assessment. Patients we spoke with confirmed that they had been offered checks such as regular blood pressure monitoring, where appropriate.

Support for lifestyle changes and healthy living was provided at the practice. This included support for smoking cessation and changes to dietary habits. Two patients that we spoke with praised the support they had received with encouragement towards healthy living. They told us about the positive outcomes this had for them. One other patient told us about the information and equipment they had been given to support them to manage their own condition and prevent the need for additional medical interventions. They told us they felt extremely well supported in this and it had a positive result for them.

The South Devon and Torbay Clinical Commissioning Group (CCG) area has a higher than the national average rate of teenage pregnancies. Southover Medical Practice had a higher than average number of patients aged under 18 than both the England and CCG averages. One of the GPs at the practice had a special interest in family planning and the practice provided advice to patients on pregnancy prevention and referrals to local sexual health services for those aged under 25. The practice promoted sexual health for young patients through their website. This included providing details of the 'Torbay C' card initiative, whereby patients could obtain free condoms and confidential sexual health advice at many locations in the Torbay area. This provided young patients with choice about where to obtain help and contraceptives.

Are services caring?

Our findings

Summary

The practice was caring. Patients told us that staff treated them with respect and understanding, they felt that they were listened to and never rushed by staff. Measures were in place to protect a patient's dignity during examinations and to provide reassurance. Patient confidentiality was respected.

Patients told us that they were provided with sufficient information to make informed choices about their treatment and their choices were respected. Patients told us that they received suitable support to manage their own conditions.

Respect, dignity, compassion and empathy

We spoke with ten patients at the practice who all praised the care they received and the caring manner of staff. We looked at eight comment cards which echoed those sentiments. Comments cards provided a number of examples of where patients felt they and their families had been treated with compassion at times of bereavement or difficulty.

Patients told us that reception and clinical staff spoke to them politely and respectfully. They also said that they never felt rushed during consultations and that they felt listened to. One patient told us they had expressed a wish not to be seen by a particular GP and that their request had been respected. They were happy with the way this had been dealt with.

Patients that we spoke to said that confidentiality was respected at the practice. We saw that the layout of the practice supported this. The reception desk was separated from the main waiting area so that people could speak to staff without being overheard. We saw there were appropriate screens and covers for patients to use when examinations took place, this helped to maintain patient dignity.

Patients were aware of the chaperone service offered at the practice and we saw posters advertising its availability. A chaperones is a person who accompanies a patient during their consultation, particularly during physical examination or treatment. A chaperone may also be used during examination or treatment of vulnerable adults and of children. They may be required to provide a written record to confirm that examinations were conducted appropriately. Members of the nursing team confirmed that they understood their role as chaperones and acted in accordance with the practice policy.

Involvement in decisions and consent

Patients told us they felt involved in their care and were able to make informed decisions. One patient described to us how they discussed a range of treatment options with their GP and chose the one they wanted. They told us they had been made aware of the benefits and risk of each option.

We spoke with patients who were aware that staff had to ask permission before treatment was carried out. We saw examples of how and when consent had been provided. We spoke to a parent about treatments their children had received and about childhood immunisations. They confirmed that they received explanations, could ask questions at any point and had been asked to sign a consent form before treatments or immunisations.

We were provided with an example of a recent situation where a person did not have the capacity to give consent. We saw that the practice had acted in accordance with the requirements of the Code of Practice of the Mental Capacity Act (MCA) 2005. This code sets out the steps which should be taken to protect patients' rights and ensure that decisions taken on their behalf are taken in their best interest. Staff demonstrated their knowledge of the MCA to us, confirming that they knew when it should be used protect patients' rights.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Summary

The practice was responsive to patient needs. Patients we spoke with told us that the practice responded well to their individual health needs. The practice had a patient participation group (PPG) which had begun to increase the voice and influence of patients in improving services.

Patients told us that they were able to get access to an appointment when they wanted one. The most recent patient survey carried out by the practice confirmed this view. Patients said that preferences, such as to see a doctor of the same sex, were responded to where possible.

Where referrals were required to secondary care at hospitals or other health providers these were made promptly and patients were kept informed.

The practice had a complaints policy which was clearly displayed. Patients told us they did not feel the need to complain but knew how to do so. Action was taken in respect of concerns raised.

Responding to and meeting people's needs

The practice was responsive to patient needs. Patients we spoke with told us that the practice responded to their individual health needs well. They said that preferences, such as to see a doctor of the same sex, were responded to where possible.

We were provided with a number of examples of how the practice met the need of individual patients. One patient told us how well their GP had monitored and met their changing health needs in respect of a number of conditions. We saw written letters of appreciation and thanks from the local learning disability community team and a local care home describing how well the practice had met individual patient's needs and praising the practice's general approach to meeting patient needs.

The practice had a weekly virtual ward team meetings to consider patients who were most vulnerable, having recently been discharged from or at risk of admission to hospital. Those patients were closely monitored each week by the team and patients' needs were reviewed and rated each time as being high, medium or low risk. Decisions about additional support for patients were taken, based upon their risk level, and preventative measures were put in place. This was in line with NHS England's 'Avoiding Unplanned Admissions' an enhanced service plan for 2014, which all practices were encouraged to take part in. The community support worker (CSW) who worked with the practice told us they worked very closely with the practice to secure additional support to prevent unplanned hospital admissions.

Where referrals were required to secondary care at hospitals or other health providers we saw that these were made promptly. Patients were able to pick their own appointment time through a choose and book system. For urgent referrals GPs completed a template, reception staff processed it and an appointment was booked. As a result people had an appointment, in most cases, before they left the practice.

The practice was accessible to wheelchair users, however, some consulting rooms were on the first floor. Health visitor appointments also took place on the first floor. There was an area on the ground floor where pushchairs could be left. One patient said attending appointments on the first floor was not easy when they had more than one child with them. The practice did not have a lift or stair lift. The practice manager and partners told us that installation of a lift had been considered but there were no plans to pursue this at present. We were told by the practice manager that they managed the issue by ensuring that ground floor treatment rooms were available as necessary.

The practice had a patient participation group (PPG) to increase the opportunity for patients to influence the service. This group was in its infancy and conducted it's business on-line. We met with two members of the group who were enthusiastic about their role. They told us they would value having occasional face to face meetings at the practice as members grew, and more direct contact with other members.

The PPG had contributed to the most recent patient survey in 2014 when 282 patients had responded to the survey which asked patients for their views and experiences of making appointments. The survey focussed on this area to assess how changes and increases in telephone consultations had affected patient experiences of booking appointments. Patient responses were positive with just over 90% saying they had been able get an appointment within 48 hours when they wanted to. Results and analysis of the survey were published on the practice website together with action points.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

All of the patients we spoke with told us it was usually possible to get an appointment within a reasonable time. They said they were usually able to get an urgent appointment on the same day, if they wanted to see a particular named GP they sometimes had to several days. We saw that the practice had a few urgent appointment slots still available on the day of our inspection This enabled them to respond to patients' urgent needs.

The practice operated a duty GP system whereby patients could receive advice and their priority considered on the telephone. The duty GP assessed whether a visit to the practice or the person's home was required. Records showed that GPs undertook a number of home visits during our inspection to see patients who were unable to attend the practice.

The practice closed for one hour each lunchtime with cover provided by a rota whereby one GP remained available. The Out of Hours service was delivered at the weekend, evening and overnight by another provider. The patients we spoke with knew how to get the services of a GP out of hours. The opening times for the practice and how to contact the Out of Hour's service were displayed at the practice and on its website. This also contained information about access to other health and social services.

Patients told us they knew how to get test results and how to obtain repeat prescriptions. They told us about their experiences of using the website and about talking with duty GPs on the phone. Two people said they used the website regularly and it worked well for them. All the patients we spoke with were positive about how duty GPs dealt with them on the telephone. Patients said any hospital referrals were managed promptly and were explained clearly. We saw evidence of referrals which confirmed that they were made promptly.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice had a designated responsible person who was responsible for handling all complaints in the practice. The practice had clear processes displayed in the waiting areas to show patients how and who to complain to. Patients we spoke with told us they knew how to complain and felt they would be listened to if they needed to complain. Those patients also told us they did not feel the need to complain. We found that when complaints were made they had been responded to by the practice in a timely manner, and action had been taken.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Summary

The practice was well led. There was an open and supportive management style. The practice had clear lines of responsibility and accountability and staff understood their roles. Policies and procedures were in place to guide safe, effective, caring and responsive delivery of the service.

Staff felt well supported in their roles and had opportunities to raise issues and to develop. Regular meetings were held to discuss and review clinical practice and business issues. Administrative staff felt supported but said they would value opportunities for more whole practice meetings.

Patient feedback was sought and acted upon and there was a developing patient participation group whose views helped to influence the way the practice was run.

Risks to the safety of patients and the continuity of the service had been assessed and measures were in place in respect of identified risks.

Leadership and culture

We spoke with seven staff . They told us they were clear about their roles and responsibilities and felt the practice ran as a supportive team. They felt the management ethos was one of openness and supportiveness. GPs and nursing staff told us they felt valued and respected in their roles. Administrative staff felt supported and listened to but they told us they would value more opportunities for whole staff team meetings.

Governance arrangements

The practice had a range of policies and procedures to inform clinical practice and maintain safety. We saw that policies had been regularly reviewed and staff used policies to inform their practice. There were clear lines of responsibility with designated lead roles. This supported staff to seek guidance from suitably experienced and qualified colleagues.

Partner GPs met every day to discuss practice issues informally and there were additional regular formal meetings to promote good communication and team work. These included monthly clinical governance meetings, business meetings and palliative care meetings. There were also separate practice nurse meetings for nursing staff to catch up, share information and feedback.

Systems to monitor and improve quality and improvement

We saw evidence that the practice undertook a range of audits. We saw a complete cycle of audit in respect of medicine prescribing. Necessary action had been identified, action had been taken and the results of the action were monitored and responded to an on-going basis.

We saw that GPs undertook training to improve the quality of practice. A recent example was that all GPs had completed a Royal College of General Practitioners (RGGP) on-line prescribing course.

Patient experience and involvement

The practice recognised the importance of patient feedback and ensured that feedback mechanisms were advertised and easily accessible. The patient participation group (PPG) was in early stages of development and was used to provide patient voices to influence the service. The practice manager had taken steps to recruit patients from a range of ages and experiences.

Identification and management of risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors to the practice. Risk assessments had been completed for health and safety relating to the building. These had been reviewed and updated.

The practice had a business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work. We were shown the plan which included an agreement to operate from a nearby practice with compatible IT systems if the building became unusable.

The practice manager provided evidence of the forward planning measures they had taken to reduce risk in relation to staffing. They showed us an example of staff succession planning to ensure there were sufficient suitably qualified staff to undertake routine blood tests. They also showed us actions taken to ensure that there were sufficient clinical staff, with locum cover as necessary, over the summer holiday period.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice was safe, effective, caring, and responsive for patients who were aged 75 and over. Older patients that we spoke with told us they felt well cared for, respected and that their individual needs were met.

The practice had a higher than England average number of patients who were aged over 75. The practice were also aware that some of those patients were at social risk and poverty.

GPs worked closely with a community support worker (CSW) We spoke to the CSW who told us that GPs at the practice were pro-active in seeking support for older patients. GPs would contact them if an older patient required social support, bereavement counselling or assistance with benefits. This indicated that the practice worked holistically with older patients as well as meeting their primary health needs.

Health protection and prevention programmes were in place for older people. Routine vaccination clinics against pneumonia and flu were organised at the practice in the autumn. These included any patient over the age of 65. Posters at the practice advertised the availability of shingles vaccinations for people aged over 70.

Three per cent of patients registered at the practice were older people living in local care homes. GPs visited patients at the homes and we saw a written letter of appreciation for the quality of care shown by a GP from the practice to patients who lived at a care home.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice was safe, effective, caring, and responsive for patients with long term health conditions.

Patients that we spoke with told us that they felt their long term conditions were dealt with well. They said that GPs were effective at monitoring and identifying problems with their existing condition. Patients said they felt involved in the care they received. One person described how they were supported with information and equipment that assisted them to manage their own condition and the positive impact this had. Records showed that staff worked effectively with other agencies to ensure patients had treatment they required such as physiotherapy or specialist equipment.

The practice had used the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. Historical QOF data for this practice showed that it had achieved high scores in areas that reflected the effectiveness of care provided for long term conditions.

Following written advice from the Local Area Team of NHS England that QOF data submissions were not required in 2013 the practice had not submitted data. Although the practice's QOF condition lists had not been updated we were shown that patient records had been.

In the absence of QOF data we asked the practice for additional sources of evidence for the effectiveness of treatments for people with long term conditions. We were provided with evidence that people with conditions including hypertension (high blood pressure) and rheumatoid arthritis had been regularly reviewed and had been invited for monitoring tests.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice was safe, effective, caring, and responsive for mothers, babies, children and young people.

Parents we spoke with were very happy with the care their families received. One person told us that their children had received high quality care for sudden illness and long term conditions. They told us they had no difficulty in obtaining appointments for their children.

Ante-natal care was accessed through a team of midwives who worked with the practice. Midwives held sessions at the practice once a week. Systems were in place to alert health visitors where children did not attend routine appointments and screening. Parents would be prompted to attend. Appropriate systems were in place to support prompt referral of domestic violence or safeguarding issues relating to families.

There were well organised baby and child immunisation programmes available. Parents told us that appropriate consent was obtained before immunisations.

There was a system of referral for young people to sexual health clinics and advice about sexual health was readily available.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice was safe, effective, caring and responsive for working age people and those recently retired.

The practice had a system for ensuring people of working age were able to get an appointment when they needed one. Extended opening hours were provided until 8pm on Mondays for people whose work commitments made it difficult to attend a daytime appointment.

Information about healthy lifestyles and prevention of illness was widely available at the practice. Staff were opportunistic in offering health checks when patients attended the practice

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was safe, effective, caring and responsive for people in vulnerable circumstances.

The practice worked closely with a community support worker (CSW) who referred people for support with a wide range of issues, such as bereavement counselling and benefits. The practice demonstrated good communication with the CSW to promptly alert them that patients may be vulnerable or in crisis.

The practice had higher than England average numbers of patients living in care homes and homes for those with a learning disability. Patients were offered annual health checks and home visits. We saw complimentary feedback from local care homes and learning disability community teams about the quality of care provided by the practice.

The practice provided care to vulnerable patients and signposting to other services which could support them. Although the practice had low numbers of patients who did not speak English, staff were aware of how to access language translation services. The practice did not have patients registered who were homeless. However, staff said that a practice in the area had been commissioned to provide care to homeless people and said they would refer people there. GPs described how they would make referrals to the local Drug and Alcohol Team (DAT) as required.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice was safe, effective, caring, and responsive for patients experiencing poor mental health.

We saw evidence that the practice worked closely with local specialist mental health services. We were provided with a recent example of the application of the Mental Capacity Act (MCA) 2005 by the practice with regard to a patient's capacity to give consent. Staff at the practice demonstrated understanding of the responsibilities under the MCA.

We spoke with two patients who had experienced poor mental health. They told us that the practice had shown compassion and that they felt they had been well supported with appropriate treatment and referrals.